



DEPARTMENT OF VETERANS AFFAIRS

8320-01

38 CFR Part 17

RIN 2900-AO21

Criteria for a Catastrophically Disabled Determination for Purposes of Enrollment

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend its regulation concerning the manner in which VA determines that a veteran is catastrophically disabled for purposes of enrollment in priority group 4 for VA health care. The current regulation relies on specific codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and Current Procedural Terminology (CPT®). We propose to state the descriptions that would identify an individual as catastrophically disabled, instead of using the corresponding ICD-9-CM and CPT® codes. The revisions would ensure that our regulation is not out of date when new versions of those codes are published. The revisions would also broaden some of the descriptions for a finding of catastrophic disability. Additionally, we would eliminate the Folstein Mini Mental State Examination (MMSE) as a criterion for determining whether a veteran meets the definition of catastrophically disabled, because we have determined that the MMSE is no longer a necessary clinical assessment tool.

DATES: Comments on the proposed rule must be received by VA on or before [Insert date 60 days after date of publication in the FEDERAL REGISTER].

ADDRESSES: Written comments may be submitted through <http://www.regulations.gov>; by mail or hand-delivery to the Director, Regulations Management (02REG), Department of Veterans Affairs, 810 Vermont Avenue, NW, Room 1068, Washington, DC 20420; or by fax to (202) 273-9026. Comments should indicate that they are submitted in response to “RIN 2900-AO21, Criteria for a Catastrophically Disabled Determination for Purposes of Enrollment.” Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1063B, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except holidays). Please call (202) 461-4902 (this is not a toll-free number) for an appointment. In addition, during the comment period, comments may be viewed online through the Federal Docket Management System (FDMS) at <http://www.regulations.gov>.

FOR FURTHER INFORMATION CONTACT: Margaret C. Hammond, M.D., Acting Chief Patient Care Services Officer (10P4), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420, (202) 461-7590 (this is not a toll-free number).

SUPPLEMENTARY INFORMATION: Pursuant to 38 U.S.C. 1705, VA established eight enrollment categories (in order of priority) for veterans eligible to enroll in VA’s health care system. Under 38 CFR 17.36(b)(4), “veterans who are determined to be catastrophically disabled” are to be enrolled in enrollment priority group 4. For the

purposes of enrollment, § 17.36(e) defines “catastrophically disabled” as having “a permanent severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that the individual requires personal or mechanical assistance to leave home or bed or requires constant supervision to avoid physical harm to self or others.” The regulation states that the definition is met if the veteran is found “to have a permanent condition specified in [38 CFR 17.36(e)(1)]” or “to meet permanently one of the conditions specified in [38 CFR 17.36(e)(2)].” Current paragraph (e)(1) identifies the covered conditions in part by assignment of particular tabular diagnosis codes from Volume 1 of the ICD-9-CM, associated supplementary codes (V Codes), tabular procedure codes from Volume 3 of ICD-9-CM, and procedure codes from the CPT<sup>®</sup>. (CPT is a trademark of the American Medical Association. CPT codes and descriptions are copyrighted by the American Medical Association. All rights reserved.) This approach will soon be outdated; the ICD-9-CM and CPT will no longer be used for disease and inpatient procedure coding after October 1, 2014, when they will be replaced by tabular diagnosis and supplementary codes from the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and by procedure codes from the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS).

Fortunately, the current regulation also lists the descriptions that classify an individual as catastrophically disabled under paragraph (e)(1). Those descriptions are the actual basis for the various assigned diagnosis codes in the regulation. We believe those descriptions listed under current paragraph (e)(1) are sufficient to classify an individual as catastrophically disabled and that it is not necessary to require the

assignment of the particular listed codes. The ICD-9-CM diagnostic codes and the ICD-9-CM or CPT<sup>®</sup> procedure codes are used to represent an actual clinical finding. An examining clinician, in practice, examines the veteran and determines the veteran's level of disability based on medical criteria or performs surgical procedures that are not dependent on the assignment of a particular code number. Once the medical criteria are met, the physician can match them to an appropriate code. In other words, the description of the veteran's medical condition—and not a particular code number—forms the basis for a determination of catastrophic disability.

It is fair to say that the new tabular diagnosis and supplementary codes from the ICD-10-CM and procedure codes from ICD-10-PCS will continue to be updated in future years to ensure accuracy of the codes. As a result, VA would need to update this regulation solely to reflect changes in those references. This is administratively burdensome, particularly when inclusion of such information is not necessary as we explained above. We therefore propose to eliminate the references to the ICD-9-CM and to the CPT<sup>®</sup> in current § 17.36(e)(1). Current § 17.36(e)(1) states that a veteran is catastrophically disabled if she or he has: “Quadriplegia and quadriparesis (ICD-9-CM Code 344.0x: 344.00, 344.01, 344.02, 344.03, 344.04, 3.44.09), paraplegia (ICD-9-CM Code 344.1), blindness (ICD-9-CM Code 369.4), persistent vegetative state (ICD-9-CM Code 780.03), or a condition resulting from two of the following procedures (ICD-9-CM Code 84.x or associated V Codes when available or Current Procedural Terminology (CPT) Codes) provided the two procedures were not on the same limb.” As already discussed, we would revise paragraph (e)(1) to eliminate references to specific codes. The descriptions of quadriplegia and quadriparesis, paraplegia, and persistent

vegetative state would be unchanged. For this same reason, we would also eliminate the references to the ICD-9-CM and to the CPT codes from current § 17.36(e)(1)(i) through (e)(1)(xviii).

In addition, we would replace the word “blindness” with “legal blindness defined as visual impairment of 20/200 or less visual acuity in the better seeing eye with corrective lenses, or a visual field restriction of 20 degrees or less in the better seeing eye with corrective lenses.” The term “blindness” in and of itself is ambiguous. The regulation associates “blindness” with ICD-9-CM Code 369.4, which applies to “blindness not otherwise specified according to [United States] definition.” It also “excludes legal blindness with specification of impairment level (369.01-369.08, 369.11-369.14, 369.21-369.22).” This is not an accurate description of who we believe should be considered catastrophically disabled for purposes of enrollment. We believe that the more specific criterion of legal blindness in the proposed definition is more consistent with most accepted definitions of legal blindness, including the definition used by the Social Security Administration (SSA) for determining whether an individual is legally blind for purposes of SSA benefits. See 20 CFR 416.981. We believe that visual acuity greater than 20/200 or greater than 20 degrees in visual field restriction does not sufficiently compromise a veteran’s “ability to carry out the activities of daily living.”

Current § 17.36(e)(1)(i) lists one of the relevant descriptions for a determination of catastrophic disability as: “Amputation through hand (ICD-9-CM Code 84.03 or V Code V49.63 or CPT® Code 25927).” We propose, instead, to refer to: “Amputation, detachment, or re-amputation of or through the hand.” Similarly, current § 17.36(e)(1)(ii) lists one of the relevant descriptions for a determination of catastrophic

disability as: “Disarticulation of wrist (ICD-9-CM Code 84.04 or V Code V49.64 or CPT<sup>®</sup> Code 25920).” We propose, instead, to refer to: “Disarticulation, detachment, or re-amputation of or through the wrist.” Again, these descriptions are listed under the codes currently listed in the regulation, and therefore there will be no substantive change to coverage of these descriptions under paragraph (e)(1). We would add detachment and re-amputation where appropriate in § 17.36(e)(1)(i) through (xvi) because we believe that these descriptions have similar clinical effects on a veteran’s “ability to carry out the activities of daily living,” as required by the definition of catastrophically disabled in current paragraph (e). Again, “catastrophically disabled means to have a permanent severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that the individual requires personal or mechanical assistance to leave home or bed or requires constant supervision to avoid physical harm to self or others.” 38 CFR 17.36(e). Detachment or re-amputation of certain limbs or body parts listed under paragraph (e)(1) would likewise meet this definition of catastrophically disabled and so should be expressly included. It should also be noted that the ICD-9-CM or CPT<sup>®</sup> codes and the ICD-10-CM or ICD-10-PCS codes have different descriptions for the same medical condition. ICD-10-PCS also introduces new terminology. For example, the term “detachment” is not used in the ICD-9-CM codes, however, it is used in the ICD-10-PCS codes. Likewise, the term “amputation” is used in the ICD-9-CM codes, but it is not used in the ICD-10-PCS codes. Where applicable, we propose to use both terms so that descriptions can be readily identified regardless of what code system is used.

Current § 17.36(e)(1)(iii) lists one of the relevant descriptions for a determination of catastrophic disability as: “(iii) Amputation through forearm (ICD-9-CM Code 84.05 or V Code V49.65 or CPT® Codes 25900, 25905).” We propose, instead, to refer to: “(iii) Amputation, detachment, or re-amputation of the forearm at or through the radius and ulna.” We would add “through the radius and ulna” because this specificity is used in the CPT® codes currently referenced in the regulation and, more importantly, removes any uncertainty about the amputation procedure being referred to in the proposed regulation. This specificity is currently provided by referencing the code number. Similarly, we would add anatomical specificity to proposed paragraphs (e)(1)(iv) through(viii) and (xi) through(xvi) to eliminate any confusion about the procedures being referred to in the proposed regulation once the code numbers are removed.

Current § 17.36(e)(1)(iv) lists one of the relevant descriptions for a determination of catastrophic disability as: “(iv) Disarticulation of forearm (ICD-9-CM Code 84.05 or V Code V49.66 or CPT® Codes 25900, 25905).” We would remove this criterion because it is redundant with paragraph (e)(1)(iii).

We propose to remove current paragraph (e)(2)(ii). Under current paragraph (e)(2)(ii), an individual must have a score of 10 or lower using the MMSE. However, an individual with a score of 10 or lower on the MMSE would always be found permanently dependent in at least 3 Activities of Daily Living with a rating of 1 using the Katz scale; or score 2 or lower on at least 4 of the 13 motor items using the Functional Independence Measure; or score 30 or lower using the Global Assessment of Functioning, which are covered by current paragraphs (e)(2)(i), (e)(2)(iii), and (e)(2)(iv). Use of the MMSE for purposes of paragraph (e)(2) is therefore redundant.

Current § 17.36(e)(1)(xv) lists one of the relevant descriptions for a determination of catastrophic disability as: “(xv) Disarticulation of knee (ICD-9-CM Code 84.16 or V Code V49.76 or CPT® Code 27598).” It should be noted that ICD-9-CM Code 84.16 refers to disarticulation of knee; V49.76 refers to status of amputation above knee; CPT® Code 27598 refers to disarticulation at knee; ICD-10-PCS Codes 0Y6F0ZZ and 0Y6G0ZZ refer to detachment of knee. We would combine these codes into one description in proposed § 17.36(e)(1)(xiii), amputation or detachment of the lower leg at or through the knee. We would, therefore, not list disarticulation of the knee as a separate description.

#### Effect of Rulemaking

The Code of Federal Regulations, as proposed to be revised by this proposed rulemaking, would represent the exclusive legal authority on this subject. No contrary rules or procedures are authorized. All VA guidance would be read to conform with this proposed rulemaking if possible or, if not possible, such guidance would be superseded by this rulemaking.

#### Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory



Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a “significant regulatory action,” which requires review by the Office of Management and Budget (OMB), as “any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in this Executive Order.”

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined and it has been determined not to be a significant regulatory action under Executive Order 12866.

#### Paperwork Reduction Act

This proposed rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3521).

### Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any given year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

### Regulatory Flexibility Act

The Secretary hereby certifies that this proposed rule would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. This proposed rule would directly affect only individuals and would not directly affect any small entities. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

### Catalog of Federal Domestic Assistance Numbers

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.007, Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.018, Sharing Specialized Medical

Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; and 64.022, Veterans Home Based Primary Care.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. John R. Gingrich, Chief of Staff, Department of Veterans Affairs, approved this document on February 12, 2013, for publication.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Day care, Dental health, Drug abuse, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Veterans.

Dated: February 19, 2013

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Robert C. McFetridge,  
Director, Regulation Policy and Management,  
Office of the General Counsel,  
Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs proposes to amend 38 CFR part 17 as follows:

## PART 17--MEDICAL

1. The authority citation for part 17 continues to read as follows:

Authority: 38 U.S.C. 501, and as noted in specific sections.

2. Amend § 17.36 as follows:

a. Revise paragraph (e)(1).

b. Remove paragraph (e)(2)(ii).

c. Redesignate paragraphs (e)(2)(iii) and (iv) as new paragraphs (e)(2)(ii) and (iii), respectively.

The revision reads as follows:

### § 17.36 Enrollment—provision of hospital and outpatient care to veterans.

\* \* \* \* \*

(e) \* \* \*

(1) Quadriplegia and quadriparesis; paraplegia; legal blindness defined as visual impairment of 20/200 or less visual acuity in the better seeing eye with corrective lenses, or a visual field restriction of 20 degrees or less in the better seeing eye with corrective lenses; persistent vegetative state; or a condition resulting from two of the following procedures, provided the two procedures were not on the same limb:

(i) Amputation, detachment, or re-amputation of or through the hand;

(ii) Disarticulation, detachment, or re-amputation of or through the wrist;

(iii) Amputation, detachment, or re-amputation of the forearm at or through the radius and ulna;

(iv) Amputation, detachment, or disarticulation of the forearm at or through the elbow;

(v) Amputation, detachment, or re-amputation of the arm at or through the humerus;

(vi) Disarticulation or detachment of the of the arm at or through the shoulder;

(vii) Interthoracoscapular (forequarter) amputation or detachment;

(viii) Amputation, detachment, or re-amputation of the leg at or through the tibia and fibula;

(ix) Amputation or detachment of or through the great toe;

(x) Amputation or detachment of or through the foot;

(xi) Disarticulation or detachment of the foot at or through the ankle;

(xii) Amputation or detachment of the foot at or through malleoli of the tibia and fibula;

(xiii) Amputation or detachment of the lower leg at or through the knee;

(xiv) Amputation, detachment, or re-amputation of the leg at or through the femur;

(xv) Disarticulation or detachment of the leg at or through the hip; and

(xvi) Interpelviaabdominal (hindquarter) amputation or detachment.

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[FR Doc. 2013-04134 Filed 02/21/2013 at 8:45 am; Publication Date: 02/22/2013]